PATIENT REGISTRATION

Welcome to Kai Family Dentistry! Thank you for taking the time to complete your patient registration.
We look forward to taking care of you!

Patient Information

First Name	**Last Name**	**Middle Initial**
Preferred Name	**Patient Is** ☐ Policy Holder ☐ Responsible Party	
Address	**Address 2**	
City	**State**	**Zip Code**
Home Phone	**Work Phone**	**Mobile Phone**
Sex ☐ Male ☐ Female ☐ Do Not Identify	**Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow	
Birthdate (MM/DD/YYYY) _____/_____/_____	**SSN**	**Drivers License #**
Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Currently Not Employed **Student Status** ☐ Full Time ☐ Part Time If applicable, name of school:		
Email	☐ I would like to opt out of email correspondence and appointment confirmations.	

Responsible Party *Individual Financially Responsible for Patient*

First Name	**Last Name**	**Preferred Name**
Address	**Address 2**	
City	**State**	**Zip Code**
Home Phone	**Work Phone**	**Mobile Phone**
Birthdate (MM/DD/YYYY) _____/_____/_____	**SSN**	**Drivers License #**
Email	☐ I would like to opt out of email correspondence and appointment confirmations.	

Primary Insurance Information

Name of Insured	**Relationship to Insured** ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured SSN or Insurance ID#	**Insured Birthdate** (MM/DD/YYYY) _____/_____/_____
Employer _____	**Insurance Company** _____
Address _____	**Address** _____
City, State, Zip Code _____	**City, State, Zip Code** _____

Secondary Insurance Information

Name of Insured	**Relationship to Insured** ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured SSN or Insurance ID#	**Insured Birthdate** (MM/DD/YYYY) _____/_____/_____
Employer _____	**Insurance Company** _____
Address _____	**Address** _____
City, State, Zip Code _____	**City, State, Zip Code** _____